Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MMC OF EAST TEXAS
1201 FRANK
LUFKIN, TX 75904

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

EAST TX EDUCATIONAL INS ASSN

Carrier's Austin Representative Box

Box Number 11

MFDR Tracking Number

M4-10-3060-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have submitted this bill a few times via mail and fax. I have requested an EOB to do an appeal and we still have not received one. I have included the notes on this date of service…I feel that we did do a lot to get this bill paid and we keep getting put off. I feel that since they can't provide an EOB they should just pay the bill."

Amount in Dispute: $10,879.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in response to the Medical Dispute Resolution referenced above. Our records show the first receipt of this bill to be on 10/21/2009 via fax. The charges were denied as not timely filed on 12/2/2009. The only other correspondence in our records for this bill was in inquiry letter received on 8/27/10. This was returned as an incorrect billing form on 9/4/2009."

Response Submitted by: Claims Administrative Services, P.O. Box 7500, Tyler, TX 75711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 5, 2009 May 6, 2009	Inpatient services	$10,879.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers'

compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 4, 2009
   - Professional fees must be submitted on a CMS 1500 form.
   - Hospital Fees must be submitted on a UB-04 form.

   Explanation of benefits dated December 2, 2009
   - 29-The time limit for filing has expired.

   Explanation of benefits dated March 26, 2010
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code §408.027 and Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Tex. Admin. Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that §408.0272 applies to the service in dispute, for that reason, the health care provider and requestor in this dispute were required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Tex. Admin. Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the Requestor finds a copy of a bill dated 06/06/09 and a nine page history of account notes for injured employee. No documentation was found to sufficiently support that a bill was submitted to the Respondent within 95 days from the date services were provided.
3. In accordance with Texas Labor Code §408.027, the Requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for services in dispute

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 4, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.